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ABSTRACT

A study examined patterns of self-directed learning among disabled adults and their adult caregivers in Lancaster, England. Data were gathered from the following sources: 117 completed semistructured questionnaires that had been distributed through carer organizations in Lancaster and Blackpool (England) and the surrounding area; semistructured interviews of 8 of the carers who had completed questionnaires and volunteered to be interviewed; and semistructured interviews with 10 disabled adults. Among both the disabled adults and caregivers, participation in self-directed learning activities was mixed. Some individuals deliberately set out to learn about the disability with which they were dealing; however, activities such as reading, writing, and asking for information were not the norm. Little evidence of planned or intentional learning was found for either group; however, self-reported evidence of learning both in relation to the social roles of being an informal carer/disabled adult and with regard to "spare time" activities was found. Few of the disabled adults or carers interviewed had participated in formal continuing education. It was recommended that consideration be given to expanding the role of continuous education as a "contiguous resource" for disabled adults and their caregivers as home-based learning technology becomes more widely available. (Contains 23 references and 13 tables.) (MN)

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Self-Directed Learning Among Adults

by Keith Percy, Dawn Burton and Alexandra Withnall

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SELF-DIRECTED LEARNING AMONG ADULTS:

EMPIRICAL STUDIES OF COMMUNITY CARERS AND DISABLED ADULTS

BY KEITH PERCY, DAWN BURTON AND ALEXANDRA WITHNALL

PUBLISHED 1995

DEPARTMENT OF CONTINUING EDUCATION
LANCASTER UNIVERSITY

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I THE PURPOSES AND SCOPE OF THE ENQUIRY

1. Background

One should not necessarily expect British and North American research interests in continuing education to be the same, but the different emphases of the research and theoretical literature can be remarkable. As we have written elsewhere, over the past twenty-five years:

> "in the United States and Canada there has been a significant outpouring of research theorising and discussion on the phenomenon or phenomena of self-directed, informal and independent learning by adults. In Great Britain there have been almost no published research or discussion in these fields."
>
> (Percy, Burton and Withnall, 1995)

One can propose two kinds of explanation for this difference. One is structural. The number of researchers, scholars, doctoral students, conferences, academic journals, publishers eager to publish and university departments in the field of continuing education is, of course, very much greater in North America than in Great Britain. In Great Britain it is doubtful if the level of academic interchange in continuing education has achieved that of a self-sustaining critical mass: there are few, if any, critical issues, theories or dialogues that run over time. In North American it is clearly different: scholars of continuing education debate their different perspectives publicly and in print, doctoral students and assistant professors review the field and from time to time charismatic full professors at major universities emerge to define for the field the new parameters of research and theory. It is in this context that the North American interest in self directed and independent learning has developed so determinedly.

The other kind of explanation for different research emphases in Britain and North America with regard to self-directed learning is the pragmatic orientation of British continuing education. There is not a sense in which research informs practice. The practical concerns are with financial and institutional survival; with enrolling students in classes, in identifying their 'needs' and in persuading them to participate in continuing education. British culture does not accept continuing education as a mainstream activity: the notion of lifelong education has yet to make any impact upon the broader consciousness. So research and theory in British continuing education are not easily justified unless they are 'useful'; to be 'useful' implies contributing to an

increase of participation in formal continuing education. It is not likely, therefore, that involvement by adults in learning which they undertake for themselves, in the community, away from the influence of continuing education professionals and which - hypothetically - may substitute for participation in formal provision would occur to British researchers as a research issue.

Nevertheless, we are clear that it should. The American literature of the past twenty five years on self-directed and independent adult learning is full of significant statistics, conceptual puzzles, important theoretical issues, evidence on the varieties of continuing education and learning, stimulating possibilities for the practice of continuing education professionals, and unanswered questions. It appears that American adults, or many of them, do learn independently. That statement is both a self-evident truism and also an empirically-based conclusion with many layers of meaning. If they learn independently, what do they learn? How, through what means? How do they begin? Are they successful and how do they know that they are successful? Do they learn logically and efficiently? What effect does the learning have on their lives? Do they know that they are learning? And so on. The questions are profound and exciting. American theorists and researchers have raised many of them over the past twenty five years and sought, with greater or lesser success, to answer them.

At Lancaster we became convinced that we should begin to contribute to this field of enquiry ourselves. Hence the empirical studies with which this report is concerned.

2. Outline of the Enquiry

Following an outline proposal, the Universities Funding Council funded a twelve month enquiry at Lancaster under the project title "Adult Self-Directed Learning and Implications for Formal Providers of Continuing Education". The funding allowed for the employment of one full-time research assistant and for fieldwork on a relatively modest scale between October 1992 and September 1993.

The aims of the enquiry were, at the onset, stated expansively:

(i) to examine the prevalence and conditions of adult self-directed learning among UK adults
(ii) to explore inter-relationships between adult self-directed learning and learning in formal and non-formal settings.

(iii) to identify implications of findings for formal providers of continuing education.

The ambitious nature of the enquiry became clear in the first few weeks. There was, in a sense, a pre-determined logic to what had to be done. The extensive literature of the field had to be acquired and reviewed. Key issues, theoretical positions and research questions would then have to be formulated. Decisions would then be required on what fieldwork would be possible, given time and resources. It was likely that a group or groups of adults in a particular social context or position would have to be selected for investigation. Research instruments would need to be developed, piloted and the empirical studies carries out strictly to schedule. Within twelve months there would remain limited time for the far-from-easy task of extrapolating from the findings of the empirical studies implications for practice in formal continuing education.

Dawn Burton was the full-time research assistant on the project. She undertook the initial literature survey and conducted most of the fieldwork. In fact, Dr Burton remained with the project for only eleven months, moving on to take up a lectureship in another University. Alison McKeachnie assisted in some of the later fieldwork.

3. Progress of the Enquiry

The review of North American and other (e.g. Australian) literature on self-directed and independent learning was completed in three months. Re-written and extended it has already been published elsewhere (Percy, Burton and Withnall, 1995).

The review made clear how much Allen Tough of the Ontario Institute for Studies in Education, and his co-workers, and correspondents, had hegemonised the field of adult self-directed and independent learning in the 1960s and 1970s. Subsequently variations, critical studies, and new perspectives had moved on from Tough's emphasis upon the rationality and intentionality of adults' learning projects. Some of the later American work touched on themes which had emerged in other Lancaster empirical studies (e.g. Percy, Barnes, Machell and Graddon, 1988) relating to the informality, even serendipitous, nature of much adult learning. As it emerged from the review stage, therefore, this enquiry adopted theoretical positions which did not assume that adult self-directed learning was necessarily rational, intentional or planned and allowed for the possibility that it was incidental and, even, unconscious.

Key questions selected to inform the empirical studies were:

(i) Why do adults choose to learn on their own and how do they start? To what extent is self-directed learning planned?

(ii) What are the processes of self-directed learning? What resources do adults use and how do they locate them? What are the costs to adults of being self-directed learners?

(iii) Do adults in different social strata and different life situations engage in self-directed learning differently?

(iv) How does one evaluate the quality of adult self-directed learning? Is self-directed learning successful - and by what criteria?

A further key question was the definition of the scope of the fieldwork. Which adults would be surveyed? It was a reasonable hypothesis that adults from different social classes, or with different prior experiences of formal education, or with different access to continuing education opportunities would engage more or less, or differently, in self-directed learning activities. However, to address this hypothesis properly would require a multi-dimensional research design with large numbers of subjects and a complex analysis which took full account of all the probable intervening variables. The present study had only modest resources and a short timescale; it was decided, therefore to research two groups of adults in the community - both of which had, hypothetically, limited access to formal educational opportunities because of their social situation. The two groups chosen were informal carers (who, hypothetically, would have little time and flexibility for participation in formal continuing education) and homebound disabled adults.

The enquiry therefore consisted of three empirical studies:

(i) A semi-structured questionnaire to informal carers distributed through carers' organisations in Lancaster and Blackpool and environs. 117 usable questionnaires were returned. Questionnaires could be returned anonymously or, if the respondent volunteered to be interviewed, with name and address.

(ii) Tape-recorded interviews, using a semi-structured schedule with eight of those carers who returned the questionnaire and volunteered to be interviewed.

(iii) Tape-recorded interviews with ten disabled adults, using a semi-structured schedule. The interviewees were contacted through support groups and through professionals in the social and health services who knew them.

II SELF DIRECTED LEARNING: THE LITERATURE

As indicated earlier, the project devoted three months to a review of previous theorising, empirical studies and discussion on adult self-directed and independent learning and that review has subsequently been published (Percy, Burton and Withnall 1995). It would be redundant to replicate the same review here. What follows in this section is an essay which exposes some of the themes in the literature review. The essay should provide a relevant backdrop to the reports on the empirical studies which follow in Sections III and IV.

What is immediately clear from the review is that it is not clear what the phenomenon is with which we are dealing. Oddi (1986, 1987) reflects quite rightly that the conceptual ambiguity of the debate about self-directed learning is proved by the number of different terms used to describe the phenomenon or phenomena under examination. Oddi identifies ten uses which include self education; independent study; independent learning; self teaching; self instruction; individual learning, independent self-education; self-directed learning; autonomous learning. Indeed, on examination it becomes obvious that the American literature on self-directed learning is voluminous partly because a large range of different but related phenomena are being discussed. A crucial distinction is between self-direction in a context which is pre-conceived, structured or constrained by an educator (that is, an educator employed, or at least socially recognised, as such) and a context which is not (and indeed may be one in which an educator has no place). Much of the American literature about self-directed learning or independent study is, in fact, about what happens in American Universities and Colleges. It is set in the context of large scale mass teaching of students with high proportions of class contact time, prescribed course content, multiple choice assessments, limited time for private study and reading around. So discussion of self-directed learning in formal courses is concerned with a goal, an alternative vision of education, ie how it ought to be - and with the techniques for achieving it. How do you motivate students to take responsibility for their own learning, to become self-actualisers, to decide in which intellectual direction they should be going and how to get there in the context of a formal course? How do you motivate teachers - used to a different system - to be self-critical, to treat their students as individuals, to learn to negotiate and to debate what is academically acceptable?

One of the doyens of American continuing education, Malcolm Knowles, offered the answer to these questions with his notion (he called it a `technology') of `andragogy'. Adults, said Knowles in his major publications of the late 1960s and 1970s, (eg

Knowles 1970) were different from children and young people. They were, and wanted to be, "self-directed personalities". So they wanted to learn, and learned best, "under conditions that are congruent with their self-concept as autonomous individuals". Thus, "a new technology for the education of adults" - androgogy - was needed in which adult learners set their learning goals, agreed a learning contract with their teachers and used, and were respected for, their life experience. Adults did not prosper, he contended, in a situation of mass teaching.

Essentially Knowles was talking about androgogy as a new technology for the classroom, for the adult in the classroom. He was saying both that adults wanted androgogy and learned best in association with it. But what then follows logically for adults outside the classroom, for adults in the community, adults left to their own devices, adults not it contact with professional teachers? Autonomous individuals, self-directing personalities were surely just as likely to set about learning for themselves, informally, in the community. And that is just what Allen Tough, the father of research into self-directed learning among adults in the community, went on to discover. Tough gave rise to the other huge outpouring of American/Canadian research on what is labelled self-directed learning. Replication study after replication study, one refinement of fieldwork technique after another, debate after debate on conceptualisations and methodologies were initiated by Tough's seminal work of the late 60s and 70s (Tough 1967, 1971 and 1978).

We contend that understanding of Tough's work on self-directed learning only becomes possible if the work is seen as coming from the same set of concerns and presumptions as those of Knowles and 'andragogy'. The key is the concept of the adult as a rationally, self-directing actor, sometimes needing help to achieve a successful rational path, sometimes stumbling or missing his/her way, but learning outside the classroom somehow in ways which are the mirror image of what should or could happen in the classroom or college.

Key publications by Tough had indicative titles such as "Learning without a teacher" and "The Adult's Learning Projects". Though a probing, projective type of interviewing methodology (and interviews might take several hours) he established that a wide range of adults undertake learning projects - as he called them - throughout their adult lives. These are intentional acts of learning. Tough tried to exclude accident. He defined intentional learning as meaning that "more that half of the person's intention is to gain and to retain certain definite knowledge and skills". (Tough 1971, 7). One may question whether intentions can be measured in this way

but Tough's approach is clear. A learning project is made up of learning episodes that might occur in different contexts spaced over a long period of time. Learning episodes might involve television, reading, asking someone, watching others, being in a group, having an instructor - virtually anything. Learning projects might involve having a mentor, as often as not a relative, friend or neighbour. Anything might be the object of a learning project; of course, we are not necessarily talking about Greek history or nuclear physics. Car maintenance, cookery, a language, often a work-related skill, perhaps something which professional education would dismiss as seemingly trivial such as the record of a football team or the more esoteric aspects of pop music appear in the literature of learning projects. And, with varying amounts of methodological rigour, Tough and his colleagues demonstrated the existence of this phenomenon, more or less, across the social spectrum, among older and younger adults, black and white, men and women, highly educated and blue collar. This was intentional conscious learning, planned at least to some extent, taking place in the community normally without benefit of professional teachers, formal learning resources and libraries.

Hundreds of replication studies followed across the world and they showed largely, that Tough had identified the essence of an observable social phenomenon. However, there have been no replication studies in the UK apart from some early work by Stephen Brookfield (Brookfield 1980) and a study by Marie Strong at Nottingham (Strong 1977). Since the mid 1970s in North America, much of the literature on self-directed learning has been critical of Tough, certainly of his methodology. Moreover there are many unanswered questions. What, in detail, are the differences between adults of, say, different economic or educational backgrounds with regard to the phenomenon of adult self directed learning? Do adults who participate in formal adult education classes engage more or less in self-directed learning in the community? What learning resources do self-directed learners really use; how do they find them; how effectively do they choose mentors to assist them in their learning? Most importantly what are the costs and benefits of adult self-directed learning? What are the dangers? Do adult self-directed learners learn ineffectually? The examples of car maintenance or house repairs are indicative: are there dangers in what one might call amateur learning? Or is that just what professionals may want to believe.

Moreover, there have been a range of psychological/philosophical/sociological debates which have been stimulated by the empirical work of Tough. A major one is whether adults have a greater or lesser propensity to engage in self-direction in learning and whether this propensity is a matter of rational choice or should be conceived as

conditioned by psychological variables (be treated almost as a personality characteristic) or is a social construct, in effect environmentally determined. The psychological approach has led to the development of more than one Self-Directed Learning Measurement Scale (Guglielmino 1977).

In the mid 1980s two Americans, Spear and Mocker challenged Tough's account of the linearity of adults self-directed learning efforts and the portrayal of the accumulation of learning episodes as relatively systematic. Spear and Mocker researched 78 adults with less than high school education. They identified significant numbers of learning projects but found that pre-planning occurred in only a small minority of cases and then only in a "vague" fashion. They concluded that learning was initiated less by the individual and more by what they called 'the organising circumstance'. The adults were in a set of circumstances which both required and allowed them to learn. Thus a change in life circumstances, a major life episode, could be the impetus or trigger for a learning project. The structure of the project, the learning resources and methods were normally dictated by time, place, circumstances such as family and money. Finally learning was not necessarily linear or progressive; more normally it was serendipitous. It proceeded crab-wise. Circumstances created by one learning episode were used as a stepping stone to the next stage of the process (Spear and Mocker, 1984).

A few years after this research, one of the Americans, Spear, took the analysis further by adding to the concept of the organising circumstance the notion of learning clusters. Adults have interests and inclinations and undertake self-contained learning episodes according to their interests and inclinations as circumstances allow. Information acquired as a result of a particular learning episode can be defined as a learning cluster and it is stored, more or less, just behind the level of consciousness, until some other information arises as a learning cluster from a learning episode and the two learning clusters locate themselves side by side, float into proximity, even coalesce. The learner may have no foreknowledge that one learning cluster may come to fit with another (Spear 1988).

The concepts of the 'organising circumstance' and of the 'learning cluster' address usefully the question of how an adult begins to be involved in a process of self-directed learning. They do so in an open way; adults may respond only semi-intentionally to an 'organising circumstance'. The notion of a 'learning cluster' to some extent begs the question of when the learning process begins. Does it begin with the first learning episode or as the learning cluster coalesces and is consciously recognised?

In Section III we consider the Lancaster questionnaire and interview studies of informal carers in the community. These were adults who had a clear 'organising circumstance' in their lives, the (sometimes sudden) requirement to care (often very comprehensively) for another and they had self-evident learning needs in relation to the new role. In Section IV we report on the Lancaster interview studies of disabled adults. For some of these traumatic, catastrophic circumstance intervened in their lives in the form of an accident and disability followed. For others disability grew gradually, or was profoundly present from early childhood. For all, however, life history was an account of changing circumstance, as the individual learned to adapt to his/her condition, to the attitudes of others, and to the resources available in the accessible environment.

III LEARNING TO BE A CARER

1. Profile of the questionnaire sample of carers

117 carers returned the questionnaire. 84 (72%) of them were female. The socio-economic profile of the respondents - based on current or last paid employment - is presented in Table 1. The profile is clearly influenced by the high proportion of females in the sample. 37% identified themselves with unskilled or semi-skilled occupations (typically sales assistant, mill worker, school meals assistant); 22% with clerical and other white collar employment (typically secretary or receptionist); 25% with professional occupations (typically school-teacher).

Table 1. Questionnaire Sample: Carers' socio-economic profile

Category	%
unskilled	20
semi-skilled	17
skilled	22
technician/supervisory	9
professional	25
self employed	1
not stated/not employed	7

Most carers in the sample were over the age of 50 (68%). The largest age group was 61-70 (30%), closely followed by 51-60 (27%). Few carers (8%) were under 40. Table 2 contains the age distribution of the carers. Approximately 32% of the sample of carers lived in Blackpool, 15% in Preston and 23% in Lancaster. Thus the sample was largely urban rather than rural. 79% of the sample lived in towns or their suburbs; 21% only lived in rural or semi-rural areas.

There were 119 people cared for by the 117 carers (that is, two of the carers had two people for whom they cared). Table 2 also contains the ages of the care recipients. It will be seen that one third of them were 70 years or more (and written in comments referred to several who were in their nineties) and 11% were under 20 years.

Analysis shows that those cared for who were 70 years or more were more likely to be cared for by carers aged 61 - 70 (41%) than by carers of their own age group (24%) or those aged 51 - 60 (25%) or 41 - 50 (12%). No carer over 60 years cared for

Table 2. Questionnaire Sample: Age groups of Carers and Care Recipients

Age Group (Years)	Carers %	Care Recipients %
under 20	1	11
21 - 30	2	9
31 - 40	5	6
41 - 50	24	13
51 - 60	29	14
61 - 70	30	16
70+	9	32

someone under the age of 20; indeed most of those caring for this age group were 41 - 50 years (60%). 60% of those carers who were 70 years or more cared for someone who was similarly 70 years or more (although, hypothetically, that person might have been twenty years older). 76% of those cared for by carers aged 61-70 years were themselves 61 years or more (two thirds were over 70).

Indeed, of the total sample of carers, 20% were caring for an individual reported as being in the same age group as themselves. It was noticeable, however, that those aged 41-60 had the widest spread of ages of those for whom they cared. 20% were over 60 and 16% under 20. Carers of this middle-aged generation, then, seemed to be supporting the generation before them and that which was coming after, as well as their own generation.

Most carers, 114 out of 117, cared for a relative. Only one was reported as caring for a friend and one for a neighbour. The socio-economic category - based on last paid employment - of care recipients is shown in Table 3. It follows that the largest group (20%) contained those who had never worked (some were children), or for whom no occupation was stated or was not known. Fewer (compared to carers) of those cared for were reported as having had professional or managerial occupations (16%). Nevertheless, there were more males among the care recipients than among the carers.

An analysis of the disability/illness of care recipients shows that 63% had one or more of a wide range of physical disabilities. The after-effects of one or more strokes was the most common condition reported but there were many sufferers from multiple sclerosis and ME. There were a wide range of other conditions identified, such as Spina Bifida, Parkinson's Disease, blindness or partial sight and paralysis following an accident. 16% of those being cared for were reported as suffering from Alzheimer's

Table 3. Questionnaire Sample: Socio-economic profile of Care Recipients.

Category	%
unskilled	17
semi-skilled	13
skilled	15
technician/supervisory	6
professional	14
self employed	5
not stated/not known never employed	29

Disease, dementia or "mental illness" and 6% from mental handicap or "severe learning needs". 4% were said to have both physical and mental disabilities and a further 4% were more generally described as "frail", "difficult", "suffering from old age". In a few cases the carer failed to identify the nature of the disability of the individual for whom s/he cared.

2. Membership of Carers' Organisations: Some implications for learning activity

It has already been established that a great deal of learning activity occurs in voluntary organisations (Percy et al, 1988). The membership of voluntary organisations, and the learning opportunities they provided for carers were an important avenue of enquiry within the research design. Out of the sample of 117 carers, 38% indicated that they were members of a carers' organisation, and 62% replied that they were not. This response is at first sight surprising given the methodology employed in the research. Since the main strategy for distributing the questionnaires had been to send them to carers' organisations to be distributed amongst members, one might have hypothesised that the proportion of members of 'carers' organisations' would be greater than the sample reflected. One explanation of the outcome may be that the term 'carers' organisation' was ambiguous for the respondent. During interviews conducted with carers it emerged that carers often considered themselves members of support groups for carers, rather than carers' organisations. Within the sample 26% of carers stated that they had deliberately chosen not to be members of a carers' organisation, and 36% indicated that they did not know that carers' organisations existed. Of the carers who

were members of carers' organisations, 34% were members of one organisation, and 4% were members of two organisations.

Carers were also questioned about the usefulness of being members of carers' organisations. Almost all of those who participated indicated that carers' organisations provided useful practical advice, enabled carers to meet others in the same situation, and were valuable for learning how to care. To a lesser extent, 'carers' organisations' provided emotional support for carers. However, it needs to be acknowledged that the term 'carers' organisation' covered a wide range of different groups. During the research it became apparent that the number of members and the financial resources claimed by different organisations varied enormously. One of the more organised groups was a branch of the Carers' National Association in Blackpool. The branch had 300 members, and was the largest outside London. The branch operated a carers' help line, produced monthly newsletters and organised monthly meetings to which speakers were invited. The branch also organised social events for its membership. At the other end of the spectrum were groups which had a handful of members, which met monthly, sometimes with organised speakers. Clearly, the financial resources available to different groups had important implications for the learning activity available to carers, as did the competence of the organisers.

The experience of carers' organisations was not necessarily a positive learning episode for all carers. This point was made by one carer during an interview,

> "We did go once, that was depressing, the average age was 70, but the atmosphere was fantastic for those enjoying it...but that was not for us. We weren't ready for that, or perhaps we chose not to recognise it".

A similar comment was made by a young carer in relation to the age profile of the carers' group he attended. He felt an outsider by not having people in his own age group to whom he could relate. On the other hand he felt that he needed support, and that attending the meetings was the only avenue open to him.

Carers were also questioned about whether they passed information they had learnt from carers' organisations onto others. Out of the sample of 44 carers who had indicated that they were a member of a carers' organisation, 37 (84%) indicated that they passed information onto others. When the 37 were asked to state the number of individuals to whom they passed information, 15 said that they did not know. The mean number of recipients of information from the remainder was 3.5. This response

at least raises the possibility that members of carers' organisations can act as mentors to other carers. Largely informal mentoring amongst families and individuals in the community is an uninvestigated phenomenon in the UK. For the most part, existing literature in this area has focused on workplace mentoring (see, for example, Marsick and Watkins 1990).

3. The Incidence of Informal Learning Opportunities from Health and Social Service Personnel

Because employees of the health and social services had areas of expertise from which, hypothetically, carers could learn about the condition and needs of the person for whom they were caring, carers were questioned about the frequency of contact with such personnel and others. The findings revealed that carers had occasional rather than frequent contact with health and social service personnel. The opportunities for informal learning from such sources therefore required close examination.

Table 4 details the reported incidence of contact by the 117 carers with doctors, hospitals, social workers, carers' groups and other possible sources of support and learning. The percentages of the sample reporting no contact with the health care professionals were as follows - 30% general practitioners, 54% hospitals, 61% social workers and 75% community nurses. Contact with general practitioners was more likely to be quarterly (28%) or monthly (19%) rather than annually (15%) or daily/weekly (8%). Contact with hospitals was more likely to be quarterly (23%) or annual (13%) and rarely monthly (4%) or daily/weekly (6%). Contact with social workers was similarly infrequent - annual (17%), quarterly (15%) but monthly only 6% and daily/weekly only 1%. Contact with community nurses, if it took place, was likely to be more frequent. 14% of the 29% had daily/weekly contact.

Indeed, the most frequent sources of contact (in each case with about one fifth of the sample) were the daily/weekly contacts with home helps (19%) and the day centre (20%). About one third of the sample reported contact with a voluntary organisation and one third with carer's group (it is not clear to what extent there was overlap between these two responses): the modal frequency of contact was monthly. Only two carers used meals-on-wheels. Four carers reported no contact at all with any of the agencies listed. The overall picture, then, was of the carer in the community coping largely alone, with most contact (but not frequent) with general practitioners and hospitals (the latter, reportedly, most often for check-ups or therapy). Day centres were an important weekly feature of the routine for a minority of carers and the most

Table 4: Questionnaire Sample: Frequency of Carers' Contact with External Agencies and Organisations

	Frequency of Contact (Percentages)				
Agency/ Organisation	Daily/ Weekly	Monthly	Quarterly	Annually	No Contact
Social Worker	1	6	15	17	61
Home Help	19	1	2	1	77
Meals on Wheels	1	1			98
Day Centre	20	3			77
Hospital	6	4	23	13	54
Voluntary Organisations	8	16	4	1	71
Carers' Group	3	19	4	3	71
General Practitioner	8	19	28	15	30
Community Nurse	14	3	5	4	75

likely source of help to visit the home on a regular basis were the home helps and the community nurses (both for specific kinds of help). Voluntary organisations/carers' groups were a regular feature of life for a significant minority of carers.

Relatively infrequent contacts with health and social services were detailed by most of the carers interviewed. One carer who looked after her mother with Alzheimer's Disease had this to say,

> "For 3 years I have not had a district nurse, or anyone else to help with her care. I've had the most help from the Alzheimer's Disease Society who send a sitter once a week so I can go out."

Another carer who looked after her 33 year old quadraplegic son said she had been given no advice whatsoever about how to care for her son. Her explanation was that there were priority cases in terms of help from health and social services. They were the elderly, those who lived alone, and people who needed injections. She said that her 'young son came way down on the list'. She said that she gave up "trying to get

help years ago." She made the point, as did other carers, that if they had learned enough to cope with their situation the external professional view of them was that they did not constitute a priority for help. Health and social services she claimed, were inevitably operating on a crisis management basis.

General Practitioners as a source of information and learning came in for particular comment during the interviews. Phrases such as 'he doesn't have the full picture of what I have to deal with' were expressed frequently. One carer observed that his doctor would not tell him the extent of his mother's or father's illness. Another common view was that as a generalist the GP did not know enough about the specific conditions of the individuals with whom carers were concerned. One carer who asked for advice from his GP about his schizophrenic son, reported that she was told, 'I'm not so sure about this, I'll have to give it a big think.' Many carers had clearly passed the stage where they passively accepted what their GP told them, and had begun to evaluate critically the information they received. One carer noted that her GP tended to consider issues from a medical position, whereas she also assessed the social implications of medical intervention and the possible side effects. Over the years she said that she had become more confident in talking to medical personnel. She said that a few years previously she 'wouldn't have said boo to a goose!', and her 'stomach turned over' before she went to see her GP. This new-found confidence had helped her define her own aims and objectives of learning about her son's condition.

Hospital consultants were also the subject of much comment by interviewees. Although many carers acknowledged their consultant's medical expertise, they commented, often adversely, on the amount of information conveyed to them and the manner of communication. One carer described his consultant as 'abrupt and not very informative'. He also went on to observe that every time an appointment was made with a consultant it was someone different. This hindered the building of a rapport between doctor and carer. However, the point was made by one carer that sometimes there might be good reason why the consultants were not particularly informative. As she explained,

> "You had to ask questions, you weren't given advice because they didn't know what was going to happen."

However, at the other extreme - it was believed - professionals could misinform. One carer whose son suffered from Spina Bifida had this to say about her consultant,

> "He told me (her son) would be blind and never see because his eyes were so bad. But I took him to see the eye specialist who said that he had tunnel vision and his eyes would deteriorate over the years - but there was nothing to say that he would go blind"

On the occasions where help had been given, carers seemed to learn a great deal. One carer whose son had cerebral palsy had experienced significant amounts of contact with physiotherapists, occupational therapists and educational workers. They had taught her about the nature of her son's illness and activities which she could do with her son to help improve his condition. In fact she later used these contacts to set up a play group for able-bodied and disabled children.

Community nurses were cited as a useful source of advice. One carer questioned her community nurse about the way she gave her husband a bed bath. As she explained,

> "There was a sister - a district nurse who popped in intermittently, so she said: "What are you doing?" so I explained the method and she said: "You are doing no more or less that we do - just carry on!"

4. Transferable knowledge, transferable skills: some implications for caring activity

If not primarily from health and professionals, where do carers - seeking to improve their caring function - receive information, the impetus to learn more and the materials from which they can learn? As we have indicated, Spear and Mocker (1984) have suggested that resources and conditions for learning are provided or dictated by a particular set of circumstances, particularly at the onset of a learning project. However, the emphasis has often been on the resources external to the individual. It is possible that carers have knowledge and skills acquired in other phases of life which the circumstance of becoming and remaining a carer causes them to re-assemble and to re-order in order to cope with their new caring roles. For this reason, in this enquiry, carers were questioned about the extent to which their existing or previous employment had helped them in their caring role.

It transpired that the learning which had taken place in paid employment was used extensively by some interviewees within the caring role. For example, one carer had been a mechanical engineer, and has transferred his skills and knowledge to construct a range of appliances which included making a lift to transport his wife up and down

stairs. Several hoists had been constructed to move his wife around the house, and to enable her to get in and out of the car without injuring his back. He had also designed an alarm system and adapted speakers and monitors from the radio and television to meet his wife's needs. Another carer who had a part-time job as a care assistant stated,

> "In the job I'm in I've had to go on courses as part of my job training. I've picked up a lot from speakers on these courses."

However, in some instances it was the care recipient who passed on the skills they had learnt in paid employment to the carer. In one case the care recipient had previously been employed as a nurse. When her husband was asked how he had learnt the techniques to bath his wife without injuring her, he replied,

> "I've learnt as I've gone along - she was a nurse for quite a long time and knew how to do it anyway. She told me what to do, and whether I was doing it wrong or not".

Indeed, it was clearly apparent in the interviews conducted in this part of the enquiry that the skills and knowledge that individuals learnt in paid employment were an important resource which they used in their informal caring role. In general this sort of transfer of skills and knowledge has not been much discussed in most of the independent learning literature. For the most part, the emphasis has been on learners obtaining help from books, other people and so on, rather than using their existing knowledge and applying it to different situations.

However, it also needs to be recognised that the 'human capital' in terms of experience and knowledge that learners bring to learning situations is highly variable. Not all carers had the ability to help themselves by drawing on previous learning. For example, when one interviewee went to the DHSS and asked for some appliances to make his mother more comfortable in bed, he was told to go away and make something similar himself. He was not able to: he recognised that he did not possess the skills required.

5. Learning about welfare benefits

Becoming a carer, we hypothesised, can be either a role into which one is put without warning (and for which some urgent new learning is necessary) or one for which there

is some advance indication or notice so that preparation and relevant learning can be planned. We asked respondents if they had known in advance that they "would need to care for the person whom you are currently looking after". 65% gave a negative response.

So we were interested to find out how, and how effectively, they learned about the finances of caring, about welfare benefits. This was an area for speedy and accurate learning for which all, surely, had a priority need.

We decided to put to questionnaire respondents a simple test of knowledge about the eligibility for certain welfare benefits of those for whom they cared. Five types of benefit were listed; all of them would have been of relevance to a majority of the sample. It transpired that a large majority knew about the Attendance Allowance (Table 5) and knew that their dependants were eligible for it. However, the level of knowledge about the other four benefits was surprisingly low, suggesting that effective learning by carers in this area was not comprehensive. What is significant in Table 5 are the numbers of 'Don't know' and 'none' responses to all of the questions. In the cases of the carer premium and respite care 65% of respondents did not answer or gave a 'don't know' response. Overall, 46% of the total possible responses for all five benefits were no response or 'don't know'. Moreover, the question did not test the accuracy of the positive responses.

Table 5 Questionnaire Sample: Carers' Knowledge of Eligibility for benefits of care recipients (percentages)

Type of Benefit	(Percentages) YES Eligible	NO Not Eligible	DON'T KNOW plus No Response
Invalid Care Allowance	32	23	45
Attendance Allowance	72	12	16
Disability Living Allowance	48	16	36
A Carer Premium	11	24	65
Help with the cost of respite care	11	24	65
TOTALS	35	20	46

A further question invited carers to indicate where, or from whom, they found out about the various types of benefits. Table 6 contains analysis of responses. What is striking were the proportions of carers who attributed social workers (32%) and GPs

Table 6 Questionnaire Sample: Carers' Sources of knowledge in relation to benefits

SOURCE OF KNOWLEDGE	PERCENTAGE OF CARERS MAKING THIS RESPONSE
Citizens Advice Bureau	8
Welfare Rights Office	17
Local Post Office	6
Voluntary Organisation	19
Carers Group or Organisation	16
Social Worker	32
Hospital	8
GP	17
Day Centre	3
Home Help	1
Community Nurse	9
Friends	24
Other*	19
Nothing from any of them	9

*Other	
DSS publications	3%
DSS offices	2%
TV	1%
Radio	1%
Library books	1%
School	1%
Health Visitor	2%
Client at work	1%

(17%) with being their sources or one of their sources of information (although contact with social workers for a large majority of the sample was non existent or infrequent - see Table 4 above). Moreover, as Table 5 above shows, knowledge of eligibility for benefits was incomplete. The three factors fit together in a logical sequence. Social workers figured as an important potential source of knowledge about benefits; contact with social workers was limited; knowledge about benefits among carers was incomplete. There was, it is true, significant reference to voluntary organisations (such as MENCAP, Multiple Sclerosis Society, Alzheimer's Disease Society) and carers'

groups as sources of information (19% and 16% respectively) and similarly to "friends" (24%). Thus, in order to learn about a matter of material significance to them, carers also turned to their peers and to their friends who, it seems, were more immediately available to them than the professional.

During the interviews respondents were questioned further about how they had learned about the various types of benefits. There appeared to be a somewhat passive response to the 'organising circumstance' of becoming a carer and a presumption on the part of some carers that somebody should have informed them what benefits they were entitled to. This reaction contrasts with the analysis of Tough that individuals proactively seek out information. This feature was illustrated by one carer's interview response,

> "Nobody told me I had to claim ... a person from the DHSS wanted to know why I had never claimed all these years for a clothing allowance. By the time I found out it was too late, the clothing allowance stopped when he was 16."

The result in this case was the financial hardship which welfare benefits could have helped alleviate. So the effect of the 'organising circumstances' is selectively partial and can clearly be mediated by contextual factors and individual perceptions.

In a number of instances discussed in interviews carers indicated that they had learned about benefits from friends who were also carers. This process is illustrated in the following extract,

> "I was given advice by a friend whose husband had also had a stroke. Another friend got the forms."

When questioned more fully this carer confirmed that the advice she had been given by her friend proved to be accurate. This was confirmed by the DHSS when she applied for the various benefits.

A number of respondents indicated that they found the benefits system difficult to deal with. In many instances attempts to receive any benefit funding were conceptualised as a battle with government bureaucracy. The interviews confirmed that voluntary organisations were a useful source of information about benefits. Speakers from the benefit agencies often gave talks to small groups. The National Carers' Association also publishes a great deal of information on the benefits which it sends out to

members. One carer had collated this information into a file several inches thick, which included House of Commons debates and an up-to-date guide to recent legislation.

It is clear that most carers found the system of welfare benefits difficult to comprehend. This, in itself, is a factor which should temper our analysis. Extrinsic motivation to learn may have been great because of potential financial benefits but the difficulties of, and disincentives to learning could have been greater. The comparison needs to be made with situations of self-directed learning in which intrinsic motivation is engaged.

6. The process of self-directed learning.

Adult educators know very little about the process of self-directed learning. For this reason carers were questioned about the ways in which they had learned their caring skills and knowledge. Respondents were asked to rank order six statements which might describe their learning processes. Table 7 contains a summation of responses, with the lowest values indicating the highest ranked statements.

Thus, in Table 7, all of the rank scores given to learning "on your own through a process of trial and errors" (with a score of 7 being given to a missing value) summated to give the low score of 160. 96 (82%) of the 117 carers ranked this statement highest with 9 (8%) giving it second place. By contrast, only three carers ranked highest the statement "you have learned from a taught course", with only three giving it second ranking. Thus the total rankings score for this statement was 649, more than four times higher than the first ranked statement. The relationship between the rankings of the 6 statements is reflected in the final column of re-weighted scores.

Table 7. Questionnaire Sample: Carers' ranking of "ways in which you have learned to look after somebody"

Statement	Total score of rankings	Re - weighted rank score
on your own through a process of trial and error	160	1.0
you have been given advice by health and social service workers	353	2.2
you have learned from friends and relatives in the same situation	550	3.4
you have taught yourself through reading, watching the TV and videos, listening to the radio and audio tapes	552	3.4
you have learned from a carer's group	590	3.7
you have learned from a taught course	649	4.1

It may be argued that the highest ranked statement, referring to "on your own" and "a process of trial and error" is of a different order from the other five more specific statements. Nevertheless, the chord it struck with almost all of the carers is notable. Society is not organised in the sort of black-and-white, question-and-answer structures, or is not perceived to be by the carer, so that a carer finding him/herself in the caring role has easily available goals, information, predictions, remedies and resources for learning which are relevant. You are "on your own"; you may not know what questions to ask or that there are answers to questions which you have not yet thought of; you learn - perhaps inadequately and haltingly - through "a process of trial and error." Of all the sources of help, advice and learning health and social service workers, once again, are ranked highest and then "friends and relatives in the same situation" (formal resources on the one hand, followed by informal). Importantly, equally ranked with friends and relatives, are the immediate tools of community self-directed learning: books, TV, videos, radio and audio tapes. Carers' groups follow next and last of all (significantly for practitioners of education and training in the formal sector) taught courses.

Given the large number of respondents who indicated that they had learned through a process of trial and error, carers were questioned about this issue further in the interviews. It quickly became apparent that the need for learning by trial and error was enforced on most carers contextually by their social isolation, rather than it being a conscious decision. A number of carers indicated that they had made mistakes from which they subsequently learned. For example, one carer whose son suffered from cerebral palsy recognised that her expectations of what she wanted her son to achieve were far too high. She had tried to encourage him to walk before he could even crawl. However, she had learned from that experience and had modified her expectations of the tasks that her son could be expected to achieve, and the possible time scale involved.

In some instances learning from trial and error was an extremely traumatic experience. One carer's mother had suffered from three serious breakdowns. On one such occasion she had tried to commit suicide by taking an overdose. From that moment the carer locked all drugs away in a cabinet and always kept the keys with him. For another carer the choice to become a carer in the first place was one of trial and error. Asked what advice she would give to someone in her present situation, she replied with an emphatic:

> "Don't do it! I feel trapped and resentful. I'm in my mid-30s, I should be out enjoying myself, not staying in and looking after my mother. Even when I go out, I'm always wondering whether my mother is OK!"

Overall, carers in the interview situation had difficult in substantiating the view that they had learned by trial and error. Many found it difficult to recollect small or relatively significant instances where they had made errors. It tended to be significant instances where they could give a detailed breakdown of events. Perhaps a more appropriate description of the process of learning in which they had engaged would be that they learned incrementally, but intermittently. Sometimes their knowledge had lagged behind their needs.

7. The evaluation of self-directed learning: a carer's perspective.

Few studies of adult self-directed learning have addressed the issue of new learners' evaluation their own learning. Whilst Tough and subsequent studies placed a great deal of emphasis on the initiation of self-directed learning, and to a lesser extent the process of self-directed learning, the evaluation of adults' learning has been neglected.

For this reason, carers who were interviewed were asked to evaluate their own learning. Most of them indicated that the fact that they had survived and coped was a measure of how well they had learned. Many spoke of becoming more organised and that they had settled into a routine. They could also identify where they had practical improvements and this, they urged, indicated that they had learned along the way. However, the most frequent measure by which carers judged the care they gave and therefore how well they learned, was through comparing it with what professionals in health and social services had to offer.

For the most part, carers considered that they provided a higher standard of care than that offered by the National Health Service. This comparison was made possible by the availability of respite care. Many carers were eligible to place their relatives in an institution (a hospital or nursing home.) for several weeks per year while they had a holiday or rest. This enabled carers to judge the care they provided with what was offered elsewhere. Most carers interviewed were able to give graphic (perhaps over - coloured) descriptions of the differences between institutional care and care provided by themselves. One recalled:

> "They said that whilst she was in there, they would get a dentist to look at her dentures which were hurting her bottom gum, (so that) she could chew - they did not do this. I got the dentist to come up here when I got her home. "They chopped her hair off - I'm darned annoyed at treatment you get. They treat them as if they are some stray dog that has gone into kennels or something."

Another carer whose husband had Parkinson's Disease also expressed her reservations at the way in which her husband had been placed in a ward with patients who had mental illness and were much older. Patients were put to bed early, she said and there was little stimulation from either the nurses who were 'run off their feet' or others on the ward. This was particularly distressing, commented this carer, because she put a great deal of effort into keeping her husband mobile and active. She had bought him an exercise bicycle to keep his legs supple, a typewriter to prevent his fingers from getting stiff, and listened to him read to help his speech. All this work and effort was undermined, she reflected, after two weeks in respite care, when he returned home, she could not have a proper conversation with him for a month, "He had got out of the habit and had become institutionalised."

The evaluation of respite care then, was one way in which carers, whom we interviewed, assessed their own learning. Another way - relevant to almost all - was by

comparing their knowledge of the person for whom they cared with that of their GP, nurse or health visitor.

8. The impact of informal caring activity on other areas of self-directed learning.

During the interview it quickly become apparent that informal caring activity generated the need for other sorts of self-directed learning. This was especially in relation to domestic labour and the management of financial affairs. Given that large numbers of carers and their dependants live on state benefits, the need to learn how to manage financial affairs was crucial. The lack of adequate compensation for being carer was noted by one respondent during the interviews.

> "If she [her mother] was in a nursing home, the health authority would pay for it. £279 I think is the limit for her to be looked after in a nursing home. But because I look after her I only qualify for the £44 attendants' allowance. Her pension has to go towards household expenses."

Other carers spoke about the need to 'shop wisely' and buy in bulk to keep costs down. The need to be able to manage financial affairs was highlighted by one carer's husband.

> "Women should learn as much as they can about household accounts, I don't just mean the shopping account. I mean things like the rates and mortgage, fuel bills, road tax, and insurance, the car."

This comment reveals that the division in domestic labour which existed prior to the illness or disability of the person being cared for, had important implications for the extent and nature of subsequent self-directed learning which occurred. Prior to his stroke, a carer's husband had paid most of the bills. After the husband had his stroke, these tasks reverted to his wife who then had to engage in a considerable amount of self-directed learning. The prevalent domestic arrangements also had implications for learning about home repairs and improvements, DIY. Many female carers had to take on tasks which their husbands had previously undertaken such as decorating, fitting carpets, and gardening. Carers would often be given advice by their disabled partners on how a particular task should be done. However, not all carers received even this limited help. One carer who single-handedly looked after her mother reported that she had learned to fit stair carpets and to decorate on her own. When asked whether she

had read any books which had helped her learn, she indicated that she had learned as she had gone along. The male carers in the sample also indicated that they had learned new tasks. However, these tended to focus on cooking, shopping and washing and ironing.

However, it also needs to be acknowledged that the extent to which carers could engage in self-directed learning in relation to household tasks seemed to be dependent on their age and state of health. For example a number of carers indicated that they bought in help with, for example, gardening because they could not cope with heavy lifting etc. The sub-contracting of some domestic labour meant that some carers did not have these opportunities of engaging in self-directed learning.

IV CARERS AND SPARE-TIME ACTIVITIES

1. Do carers have spare-time activities?

About 40% of the questionnaire to carers was concerned with the "spare-time (if you have any) activity" of the carers. The rationale was to examine if carers - who, hypothetically, had more, and more unpredictable, demands upon themselves and their time while at home than many other members of the community - had hobbies or interests and to chart the processes of self-directed learning associated with these. Some of the questionnaire respondents told us straightforwardly that such questions were not relevant to them in the situation in which they were placed.

However, over one hundred of the questionnaire respondents did identify a main "hobby, interest, spare-time activity." Table 8 gives the reponses. It uses a somewhat crude categorisation of spare-time activity into domestic and external, and activity-based and non activity-based, which is bound to be approximate.

Sports related activities appeared as the most popular, especially swimming. Voluntary activity was second, closely followed by gardening. The multiplicity of different responses to the question, within a relatively small sample raises questions about the use of highly structured methodologies to identify people's interests. The work by Sargant (1991), in which respondents were presented with a list of hobbies from which to choose, experienced similar difficulties.

Table 8. Questionnaire Sample: Main Hobbies, interests and spare-time activities of carers

Activity	Percentage of Sample Engaged
Domestic Activity-based	
Gardening	10
Cooking: Do it Yourself	1
Domestic Non Activity-based	
Reading	9
Handicraft	8
Television	3
Piano	2
Academic	2
Jigsaws; Local History; Painting	1
External Activity-based	
Sports/Physical Ability	13
Voluntary activity	11
Walking	3
Driving	2
Dancing; Boating; Church; Travel Flower-arranging	1
External Non Activity-based	
Bingo; Theatre; Auctions	1
Multiple Activity	16
Not stated, Not clear	11

When asked to indicate how long they had been interested in their chosen activity, most carers indicated over 5 years (see Table 9).

Table 9. Questionnaire sample: analysis of how long carers had been interested in their chosen activity

	Percentages
less than 1 year	3
1-5 years	21
over 5 years	65
no response	12

This finding supports Brookfield's view (Brookfield 1980) that individuals have long term interests which they pursue, rather than short term learning projects. This conclusion was also identified during the interviews. One carer who collected antique dolls had this to say,

> "I've collected the dolls for about 10 years now, but you can't afford to buy them any more. Sometimes at an antique fair you can pick up an odd head that's been dug up, and then its quite good fun getting bodies, wigs and eyes and re-creating the thing."

Another carer who bred pedigree cats indicated that he had been interested in the activity for around 12 years. Clearly many carers had long term interests which they sustained over a number of years. However, because of their circumstances other carers took learning opportunities as they arose and were therefore opportunist ie in their interests. For example, one carer had attended a ten week sugar craft class at a local school, because it was a convenient location and only lasted two hours a week which was the most she could manage in addition to looking after her son. Clearly there was no single pattern. The question of whether adults have long term interests or pursue short term learning projects merits further investigation, we suspect.

2. Getting Started: How do people become interested in their spare time activities/interests?

Within the self-directed learning literature there has been a great deal of analysis on the topic of learning projects and the number of hours which individuals devote to learning activities. However, there have been fewer attempts to uncover how adults initially become interested in their chosen activity. In this study, the responses from the questionnaire indicated that most carers (56%) had, on their own self-report, always been interested in their activity (see Table 10).

Table 10. Questionnaire Sample: How carers had become interested in their activity

	Percentages
A relative/friend suggested it	15
Out of curiosity	4
From something you saw on television	3
Through reading a book	3
Always been interested	56
Cannot remember	3
Other	11
No response	6

The next most frequently occurring category was that relatives or friends had suggested the activity (15%). During the interviews one carer recalled how her friends had suggested various activities to her to enable her to have some interests outside the home. As a result, she had joined a local photography club, and went to the gym once a week. These activities gave her a break from the caring routine of looking after her husband. Fewer than 5% of the sample indicated, severally, that they had begun their interests out of curiosity, from something they saw on the television, or from reading a book. 11% suggested 'other' means through which they became interested in spare-time activities. One was described as a pure chance. This was illustrated in an interview in which a carer described how he had become interested in cats.

> "About 12 years ago we were witnesses to a road accident in Farnborough and we had to go and give evidence. We stayed at this hotel and the lady there had pedigree cats. At the time we had a Burmese, but we got talking to her about cats. She said 'have you ever seen an Abyssinian cat?', we said 'no'. She said 'I've just bought one', so she brought him out to show us and that was it - we were hooked. Then we bought one of our own when we went home."

A change in life circumstances was also a prompt for one carer. When he found out that his son suffered from schizophrenia he took it upon himself to find out as much as he could about the illness. His studying around the issue of schizophrenia had turned into a time consuming spare time activity. Stimuli to taking up interests or activities cited by other respondents included retirement; being asked by an outsider; altruism;

reviving a skill acquired as a youth; "seeing a need"; and more bluntly - "it had to be done" (the garden).

Overall, there was little evidence that individuals systematically constructed learning projects for themselves. More useful was Spear and Mocker's (1984) concept of the organising circumstance, which argues that a change in life circumstance often acts as a trigger for a learning episode. Clearly, this was evidently the case as far as some carers were concerned. New interests and activities had been generated as a consequence of them becoming a carer. There was also evidence of individuals who took advantage of learning opportunities as they presented themselves - as Danis and Tremblay (1987, 1988) have already pointed out.

3. Where are spare time activities carried out?

The studies which have assessed where self-directed learning occurs, have indicated that the home is the most popular location (Penland 1979; Sargant 1991). In this regard the sample of carers was no different, 56% of carers acknowledged that they carried out their interests at home, whilst only 2% indicated at a friend's house. The findings also revealed that 26% of carers undertook their hobby at an organised meeting place and 3% stated at a college (see Table 11). In view of the nature of much caring activity which tends to be home-based, the results are not surprising.

Table 11. Questionnaire Sample: Where carers undertake their interests

	Percentages (More than one response possible)
An organised meeting place	26
At a college	3
At home	56
At a friend's home	3
Elsewhere	19

The low levels of college attendance had important implications for the numbers of individuals who were attending taught courses [compare also Table 7 for those who learned their caring skills from a taught course]. Only 16 (14%) out of a sample of 117 indicated that they were taking a formal course of study in relation to their interest or hobby. Of those 16, 15 respondents had embarked on courses which were below GCSE standard. When questioned whether they had ever taken a taught class related to their interests, 28 (24%) respondents indicated that they had. Clearly, learning about one's interests through taking a formal course of study did not appear to be a popular option amongst this group. However, when individuals were asked about how they evaluated their own learning, the acquisition of certificates was cited frequently (see below).

4. How much time do individuals spend on learning activities?

When asked how long they spent on their spare time interest or hobby nearly 40% of the sample of carers indicated between 2-5 hours, 28% over 5 hours, and 21% less than two hours per week. These figures seem to suggest that self-directed learning activity takes place for more hours than if the respondents were to have joined a taught course of approximately two hours per week. However, during the interviews, carers indicated that they spent more hours engaged in spare time activities than the questionnaire data suggested. For example, several individuals took part in voluntary activity for one or two days per week. Another carer identified three different activities which she pursued which certainly took up more than five hours per week. It may be that the questionnaires encouraged underestimation of the time people were spending on spare time activities. One reason for this may have been that carers compared the activities they used to be engaged in before becoming a carer. In most instances, they had had to give up many of their interests, and this was especially the case when the activity was dependent on the physical well being of a partner. For example, one carer and her husband had competed regularly in American dancing competitions until he contracted Parkinson's disease.

Indeed, when asked whether being a carer inhibited the pursuit of hobbies 80% indicated that it did. This point was highlighted by one carer who had this to say,

> "I do nowhere near what I used to do ... there are lots of things that I want to do, but mentally I keep putting them off until the time comes when I am on my own."

Carers believed the activities in which they could engage were constrained by their caring role. Another carer indicated,

> "I love reading, I used to read a lot of books, but I can't do a lot of reading when mother shouts but, it is difficult to concentrate."

She had also had to give up drawing and painting because of the interruptions and breaks when she needed to look after her mother. Instead she was confined to spending relatively short amounts of time engaged in doing more 'superficial' things such as crosswords and watching the television. This was a scenario which was recounted by a number of carers. Tough's (1971) work highlighted the view that socio-economic class in terms of occupation had important implications for the amount of time which self-directed learners devoted to learning. The research with carers indicated that the circumstances and life-style were important variables, and that they should be given closer attention in further research.

The isolation associated with the home-based nature of caring activity was reflected in the relatively small percentage of carers who had joined a club related to their chosen interests. Fewer than 30% were members of clubs, 61% indicated that they were not. Another question related to the cost of hobbies/interests per week. Two thirds of the sample indicated that their hobby/interest cost money. Nearly 50% of the sample indicated that they spent between £1-£5, 12% under £1, and 10% over £5 per week.

5. Spare time activities and the process of self-directed learning

Tough's analysis of the self-directed learning process focused upon a linear learning route, whereby learners would plan ahead and use source books, experts and the learning resources as they went along. By contrast Berger's (1990) research indicated that individuals had more of a trial and error approach and changed course and followed different avenues of enquiry as they progressed. The questionnaire, in an attempt to consider how carers had learned about their various interests, asked about the help carers had received from a range of sources. Around 40% of the sample indicated that they sought guidance from magazines and books. The next most significant category was consulting an 'expert' which was acknowledged by 33% of the sample. Friends and family were, by comparison, used for advice less frequently (see Table 12).

Table 12. Questionnaire Sample: To whom or to what do self-directed learners turn for advice?

	Percentages
Friends	23
A member of the family	13
Magazines and books	41
Someone you regard as an expert	33
Elsewhere	5

However, an analysis of the sources used by self-directed learners without consideration of how the various sources interact together over time may miss the point. The self-directed learning process is complex, as the following extract by one interviewee on the subject of how she dated her antique dolls illustrated,

> "There are books that tell you ... this one at first glance you think ah! that's a kind of late 1930s doll - and it isn't. One of our ladies at [her former employer] had one of these on her bed and she said that was mine when I was a child! I thought no - too modern for that but it isn't, because you see them in the books, it's a sort of 20s doll. See you don't think about making this composition stuff that early, but they did. Because they were experimenting with dolls said to be unbreakable, it followed in the wake of the porcelain head ones. We had lots of dolls when we were young, we had ones with pot heads, it's like the difference between a china cup and an earthenware one."

Even within this short extract this carer revealed a number of learning experiences which she brought together to make sense of the age of her dolls. The process resembles the concept of learning clusters identified by Spear (1988). Learners use learning episodes and fit them together as they would a jigsaw. This learner knew from her childhood experience about the age of dolls, she used books to date dolls with which she was unfamiliar. Learning contacts with other people who had dolls confirmed her own knowledge as being correct, or led to further learning experience to test out what she knew. It also emerged that she had been to an evening class to learn about making dolls heads; which is how she knew about the different composite materials from which the heads were being made. Finally, her sister collected antique

dolls and had recently sent her collection off to Sotheby's to be sold. Clearly information was passed around the family. This example indicated that the self-directed learning process is complex, and in this instance lengthy. This individual had been learning about antique dolls for around 50 years.

She was also a good example of the ways in which individuals' interests develop and move on. She had always been interested in sewing, ("all the family was,") which was passed on through their mother's interest. She then progressed to making dolls clothes, then to antique dolls. When she gave up work to become a carer she began to make satin cushions inscribed with messages which she sold through a local shop. This activity provided her with extra money to supplement her small carer's income. She then became 'fed up with doing the same thing' and had moved onto cotton picture cushions. Her next challenge was to make white cotton lace cushions which she hoped to sell at craft fairs. The progression to different activities had not appeared to be systematically planned as she stated, "I buy them [cushion packs] when I see them." However, the cushion making was an important activity in her life. She said, "I find it relaxing and creative," a contrast to the negative images she had about being a carer.

6. An evaluation of self-directed learning from a carer's perspective.

The evaluation of self-directed learning is an issue which had been neglected in most of the literature on the topic. Carers were therefore questioned about how they evaluated their own knowledge and skills of their interest/hobby/activity. The first question asked carers to consider whether they thought their knowledge had developed since they began their chosen activity. Around 70% of the sample indicated that they thought their knowledge and skills had developed, 15% indicated not, and 15% failed to answer the question. Carers were then presented with a range of options from which to choose the one which best described why they believed that. The most frequent response given by 60% of the sample, was that they understood more about their hobby/activity than when they first started. Around 40% of the sample indicated that they felt more confident about their hobby/activity. This finding was closely followed by 31% of carers who felt that they had learned successfully because other people sought their advice. At the other end of the range, only 10% of the sample measured the effectiveness of their learning by the acquisition of an award (see Table 13).

Table 13. Questionnaire Sample: An evaluation of self-directed learning from a learner's perspective

	Percentages more than one response
I can do/understand more now than I did when I started	60
I have compared my ability with others doing similar activities	23
Other people ask my advice	31
I am invited to talk or exhibit work at groups, meetings or exhibitions	13
I have obtained an award/certificate	10
I have earned money from my interest	11
I feel more confident about it	40
I can tell when I am making a mistake	28
Other	2

During the interviews a number of ways in which learners evaluated the extent of the learning activity emerged. One important measure was through some tangible outcome, whether that was a certificate or a trophy. A couple who had been accomplished Latin American dancers proudly displayed their trophies and photographs. Another couple who bred pedigree cats also evaluated the extent of the learning in terms of the numbers of certificates their cats had won in shows. As he stated, "We have been very fortunate, we have never come away from a show without a first, second , or third."

This show of success was all the more satisfying because the carer had bred the cats himself. As a result of his expertise he had also been asked to contribute to an Abyssinian cat newsletter which was distributed at monthly intervals to members. The view that he had become an expert in his chosen field was an important way in which he evaluated his own learning. This point is rather like the one highlighted by Brookfield (1980). Another way in which carers evaluated their learning was by earning money. Clearly, the carer who sold her cushions to supplement the household income used financial rewards as an important method of evaluation.

Several carers evaluated their learning activity in terms of the help that it gave to others. For example, many carers did voluntary work, which often involved working in charity shops. They had learned how to help out in the shop, sort out clothes and books which were suitable to sell, and those to discard. Many carers said they liked the idea of helping others out who were less fortunate than themselves, and found it rewarding.

A final area of evaluation was the help one carer could give to professionals. One carer who had a long experience of dealing with his son's schizophrenia had been asked by social work students if they could borrow his many books, newspaper cuttings and video-tapes on the topic. The extent to which others wanted to borrow his learning materials and asked him his opinion was one yardstick by which he evaluated the extent of his own learning.

V DISABLED PEOPLE AND SELF-DIRECTED LEARNING

1. The Sample

Ten disabled adults were interviewed about their disabilities, about the knowledge they had of their disabilities and how they had acquired that knowledge, and about their spare-time activities and associated learning. There were seven men among the ten; seven of the interviewees had significant physical disability and four severe hearing loss. The physical disabilities included both congenital conditions and the after-effects of car accidents. At least two interviewees had been disabled since birth. One man was 33 years old; two interviewees were in their seventies; the remainder were aged between 38 and 53 years.

The sample had no connection with the carers' sample discussed earlier in this report. The ten disabled adults were in no sense a representative sample. They were invited to participate on the recommendation of disabled peoples' support groups or of professionals who knew them. The interviews were conducted from a semi-structured schedule and, as far as possible, tape-recorded. There were instances when the interviewees preferred to talk with the tape recorder switched off.

2. Awareness of Hearing Loss/Mobility Difficulties

The ways in which respondents become aware of their difficulties were extremely varied, and often involved a learning process which occurred over a number of years. The acknowledgement that individuals had hearing and/or mobility problems often became apparent after a period of denial that anything was wrong. For example when asked 'When did you first become aware of your hearing loss?' one response was,

> "It is difficult to quantify that exactly, only in later years have I agreed that I have hearing loss, but with reflection and hindsight it goes back to the 1950s."

This respondent indicated that it was only in the 1980s that he had to admit that he was suffering from hearing loss. The situation came to a head when he could no longer hear the conductor in the choir he used to attend. At first he blamed the conductor for not speaking up, but then he realised that he had difficulty in hearing in other situations. As a chair person of the local parish church committee he could not hear what everybody was saying, so he had to resign. Both these incidents combined with the fact that over a number of years there had been long standing battles in his

household over the volume of the stereo, led him to seek advice from his GP. Because hearing loss is to a large degree 'hidden' or 'invisible' this makes the process of denying there can be a problem easier. However, the same process was also observable in relation to mobility difficulties.

A subject who had Cerebral Ataxia indicated that he ignored his mobility difficulties even though he was well aware of what was happening. As he stated,

> " had problems with my balance, I wasn't walking in a straight line. I was staggering and looking drunk to other people, they used to stare at me as I was walking past ... but I still didn't take it on board. I think it was probably denial."

Even though this subject's disability was clearly visible, the process of denial was still apparent. Much earlier he had recognised that there were signs that something was wrong. He noted, 'Looking back in my childhood, I can see instances where my balance wasn't very good. Like for instance, walking along walls - I fell off.' This respondent only sought help at the insistence of his employer, 'I was a postman and they made me go and see a doctor, otherwise I wouldn't have gone at that time.'

It was common for subjects to have learned about the nature of their disabilities from a variety of sources. This factor was further reinforced by another respondent who claimed that she first noticed her hearing impairment when her husband developed Parkinson's Disease which affected the muscles in his face and throat. This meant that she could not always hear what he was saying. Then she was watching the Promenade Concerts on the television and found that she could not hear the triangle. At meetings she could not hear the main speaker because of the background noise around.

3. Respondents' Knowledge of their Disability

The respondents' knowledge of their disability was variable. However, this appeared to be a function of whether they had a recognisable condition which could be 'labelled' and of what was known about their particular problem by the medical profession. One respondent who suffered from Cerebral Ataxia was particularly well informed,

> "I suffer from Cerebral Ataxia, but the more common form is Frederick's Ataxia. It's a neurological condition very similar to Multiple Sclerosis, it affects balance, co-ordination and speech ... the progression is a lot slower than

MS but I'll get there eventually. I am definitely getting worse, I can tell now, I could tell a few years back. For example, three years ago I didn't use a wheelchair ... now I can't even walk across the room without holding on to something. So I know I have got a lot worse, progressively."

Where an identifiable specified illness was not apparent, respondents tended to give a list of their ailments.

4. Advice from Medical Personnel

Overall the advice that the respondents in their survey received from medical personnel was varied.

The respondent suffering from Cerebral Ataxia indicated,

> "The medical people didn't tell me anything at all. The said you've got Cerebral Ataxia and that was it ... When I was diagnosed I spent 6 years angry and frustrated because I didn't know anything about the condition or anyone with the condition except from my brother, except he's worse. He was diagnosed at the same time as I was. He's a lot heavier than I am and the weight affected him a lot more."

A subject who had had a stroke, said,

> "There is very little advice. There isn't much psychiatric counselling help available at the moment. I would think that all the medical advice I was given, was by the district nurse."

A respondent suffering from a spinal condition,

> "Medical guidance was not available, we more or less asked other disabled people, who were new acquaintances because I was projected into a new world ... nobody steered me in the right direction, I had to find my way through the maze on my own which is very common. It's quite traumatic actually, we often went round and round in circles ... The part I found most difficult was what I call the 'transitional period', where people consistently knew more than I knew medically, but let me to believe it was psychological ... doctors could have

helped by explaining the phrase "You'll have to live with it", I actually know what they mean now, they mean that you're not going to get any better."

Respondents who had been disabled over a long period of time were able to give an assessment of how medical attitudes - in their perception - had changed. In some instances the changes witnessed had been positive,

> "First, when I got one of these [hearing aid] over 20 years ago, in them days they shoved it in your ear, said "right there you are", and that was it, they said nothing just give it to you and out you go. Now they do tell you to turn it down and gradually get used to it by degrees, and just wear it a little each day. I've learnt this on my own."

Other respondents were less convinced that there had been significant changes in the attitude amongst the medical profession.

> "Doctors are more open with patients, but certainly not enough. Take my recent experience of the neurological unit. Because of lack of finance the government has put so many demands on existing neurosurgeons teaching other neurosurgeons that they have to go through all the teaching process, and the patient is not allowed to speak until the last 5 minutes. You feel that you are a number."

One respondent recalled when he was 13-14 years of age, doctors operated on his heels to straighten them and on his knees. He was in plaster for two years, had 180 stitches, and his condition was worse when they had finished. His verdict was,

> "I don't believe in doctors. I get my own advice from my brother, he's a lecturer in human biology, and my mum's a nurse."

A lack of empathy was described by one subject:

> "We never once had another disabled person in a position of authority who could direct us We always had to speak to able-bodied persons who were very nice, but did not have empathy for our needs."

5. Other Learning Sources

Several of the respondents were members of voluntary organisations which represent individuals with their particular disability. However, the process of learning about the existence of such organisations was often problematic. As one respondent recalled,

> 'I read an article in 'Woman's Own' and there was a picture of a girl who had Frederick's Ataxia, so I wrote to her and she gave me their address.'

This subject received newsletters and other correspondence from the group, but found the Annual General Meetings particularly useful

> "I found AGMs where I can talk to the experts face-to-face very useful, it took a load off my mind. I met other people with the same condition so I didn't feel so alone. Being able to talk about it with other people with the same condition got rid of a lot of the bottled up frustration."

However, whether or not voluntary organisations were considered useful depended on the expectations of the learner. For example, one respondent was disillusioned by the Spastic Society. Speaking about why he was not a member he said,

> "It's not worth it really, you see the - Spastic Society. The National Spastic Society don't give any money to people who want it because they're always skint. The local Spastic Society don't have any money."

Television, and the media generally, were not held to be a good source of advice/learning for disabled people. Some respondents indicated that this, in their view, reflected the way in which the issue of disability has become marginalised. The exception to this was the BBC's 'See Hear' programme, which a number of the sample watched and also subscribed to the magazine produced to support the programme. Several individuals had bought their own books on the issue of disability, but this was a minority of the sample. One individual had been on a residential course for the hard of hearing in Eastbourne at the 'Civic Centre'. A thorough assessment of the total person in relation to their disability, spare time activities and their way of life had been considered during the course.

The learning opportunities available to disabled people in relation to the nature of their difficulties, then, seemed to be limited. However, one respondent indicated that it is 'hard to give advice because no two disabled people are the same.' He went on,

> "Some disabled people can't move at all, some can. Some of them are in pain all the time, some of them can't feel it. It depends on how you become disabled, what by, and how old you are. Because as far as I'm concerned I've passed my trade, apprenticeship, my trade for being disabled but it takes about 30 years to get fully qualified to know what you want."

This respondent, who was born disabled, clearly distinguished between different levels of learning and used as a parallel the stages of learning he had undertaken as an apprentice engineer. He emphasised how difficult a task it was to give advice and guidance to disabled people because of the complex nature of their disabilities. To the extent that this is true it will have important implications for the quality of the learning experience available to disabled people. However, another respondent played down the complexity and uniqueness of the whole issue of disability when she stated, 'Life is a learning process, my disability goes hand in hand with that learning process.'

6. Disability and Access to Formal Learning Opportunities

> "Access is not only physical. A lot of educationalists believe that to provide a ramp and various other things is to make the building accessible. It's much more than that, especially with born disabled people, because they have been taught from day one to accept help because they cannot manage to do things and they have not had the opportunity to acquire an education. So to go to an educational course, in their mind, they believe it is higher education. They don't believe it is the opportunity to acquire a basic education. So I feel that to provide basic education in more satellite courses rather than college ... would help greatly."

This was the view of one founder member of a disability group in Barrow. As a former college lecturer she clearly had a highly developed notional of what the concept of access involved. The point she made about the psychological barriers that disabled people face in accessing taught provision was reinforced by the learning experiences of one of the sample who was born disabled,

> "I want to do an engineering degree but can't spell ... I wasn't taught to spell. You see when you are young and disabled you are put in a school where the teachers just play around and don't teach you anything. That's what I didn't like ... In a normal school I would have been taught to spell and read and write and all that. But being disabled it's the opposite way."

A lack of confidence was also expressed by one of the respondents who had mobility difficulties because of an accident he had suffered. Two car accidents had led him to have to give up work as a quarry man, a job which he enjoyed a great deal because it was physical and involved working outside. During the interview he avoided questions about 'academic' type interests and learning. In the end he stated, 'I don't actually know what I am capable of.' In the past his work and spare time interests had been physical activities such as 'swimming, badminton, squash, motorbike racing.' It was significant that he tried to keep some of these up despite his disability. He was a member of a quarry club, a disabled basketball team, a driver for the disabled club and a swimming club. He had also gone to 'night school' to work on a hovercraft project where he had learned the skills of fabrication and welding. Clearly, this respondent was very capable, yet because of his work history and leisure time activities he resisted the idea of attending a taught course. There appeared to be a need for an extensive element of advice and guidance provision before some disabled people would commit themselves to some types of courses.

A similar point, but expressed differently, was proposed by another respondent who urged the need for study skill/preparation courses. Prior to taking up studying again, he had spent much time sitting at home watching the television. He felt he would have benefited from study skills tuition such as listening skills, taking notes, and learning in a classroom environment. A course of this nature would have helped him to assess his own abilities in terms of what he could physically cope with. As he explained , 'after 2-3 minutes my co-ordination starts going to pot and I can't take notes.' For this reason he felt that an English course was unsuitable for his needs because it involved lots of writing whereas conversational French was something he felt capable of.

The special needs of people with hearing difficulties in a formal learning situation was also highlighted during the interviews. The proposal that courses should be set up specifically for the disabled was favoured by one subject. Speaking of his lip reading class,

"All the people that go are deaf, so of course they know you are deaf and you can talk to each other and if they don't hear what they say you might say 'no' when you should say 'yes', and things like that, well they know you can't hear properly, and they can't hear properly so you get on like a house on fire - they're all in the same boat."

Many hard of hearing subjects spoke of the importance of being organised when attending taught classes,

"You learn to sit in the right place when you are in a room with other people, if you talk to somebody you make sure the ear that works is pointing in the right direction. Also when it initially happened, I learned to lip read quite quickly ... I also find it helpful if I can see people's lips moving even if I can hear what they are saying."

The importance of having a tutor sympathetic to the needs of disabled students was also mentioned by one voluntary organisation official. She indicated that they paid their tutors very well and needed 'decent' tutors, not those that were merely well-qualified. She also had some interesting points to make in relation to the timing of course for disabled people,

"Summer and winter doesn't make any difference for disabled people because unlike non-disabled people they don't have a choice, so they will turn up in the snow because they have nowhere else to go. The other alternative is to stay in, look at their own four walls and to watch television ... the lack of access prevents people having choices."

7. Spare time activities

The range of activities undertaken by respondents was varied. Voluntary work figured prominently as one might have expected given the way the sample was selected. One respondent who was vice chairman of a local disabled persons' organisation indicated that he had learned a range of skills associated with computer information technology and compiling newsletters as a result of his voluntary work. This interest has also led him to go to college to learn more,

"I have been to three Colleges, I have done three years of computer courses. I am not very fast because of lack of co-ordination, and am not as proficient as I

would like to be. I started off in 1986 doing a basic computer course, I was then nominated [at the local disabled persons' organisation] to put a database together, word process letters, a mailing list, membership list and accounts."

Another respondent cited an extensive list of skills which she had to learn as founder of a disability group in Barrow. These included constructing business plans; she had learned at an early stage that applications for funding would not even be considered without a business plan. As a result along with a friend she read books from the library and networked amongst friends and business people in the area that could help. Similarly, she was clear that negotiating skills were important in dealing with statutory bodies. Often there was the need to cite statistics to press their case. She had had to learn how to handle statistics. Strength of character and confidence, and improvements in her standards of English to be able to write high quality letters were also important. She indicated that books, courses, contacts, and observation were all used in the learning process.

Apart from voluntary work, several respondents reported that they had an interest in information technology. One respondent used his computer to play chess,

> "I've got a word-processing package on the computer, I've got a chess programme on the computer ... it was suggested that I should try it by a friend ... At [the] Day Centre they had a chess programme that's how I first became interested."

He played chess for about three to four hours a week and when asked whether he had become more proficient he stated, 'I can progress to a better programme, I have a basic programme at the moment.' He added, 'I play with a friend occasionally.' Another subject had been interested in computers for around 15 years. However, his special area of interest was designing graphics and pictures. A measure of how proficient he had become at this activity occurred when he was asked to design a new logo for the local Spastic Society. However, this achievement was tarnished when the local Society later admitted that they could not afford to change over to the new logo that he had designed. He read several PC magazines which helped him to learn further about his interest. In response to the question 'Do you borrow books from the library? he said,

> "I don't believe in the library, I'd rather have my own books, so you can go back to them. I've always bought books."

This subject also had an interest in clock making and antiques and also took the relevant magazines associated with this interest. A final interest was bird watching but he indicated that he could not afford to be a member of a club. Out of a whole range of interests, this subject only went to a taught course for one of them. He had been attending night school for four years on a model making course run by the local college to build a hovercraft.

Other respondents went to several taught courses. One lady was a member of the local University of the Third Age group and had attended a number of taught courses such as history, human biology, anthropology, amongst others. She was also a tutor for two U3A music classes. More recent interest included craft work such as making stuffed toys, quilting and Christmas cards. She spoke of a need to keep busy since her husband died and the U3A course had filled a gap which might of otherwise been taken up by watching television. However, she also mentioned that keeping busy and having lots of hobbies was impressed upon her as a child by one of her teachers.

Whilst engaging in learning activities which were not home based was given priority by some respondents, the opposite was true of others. One subject spoke of why he had chosen knitting to be his main spare time activity,

> "Knitting has a big advantage that you're not dependent on special things like good weather ... you're independent, you can do it at home, because we have it in a room that's not used for anything else you can go any time you like. You can't do that with photography, you've got to get all your gear together, set off somewhere and wait for the right light, it can be quite time consuming."

Originally he had become interested in knitting through his wife. She bought a knitting machine which came with several free lessons. At the time they had a boarding house and she was unable to take advantage of the lessons so he took them instead, and then passed the information on. After the lessons were over he had become hooked. His interest had led him to go on a knitting seminar. He had also visited knitting exhibitions all over the country. As he became more proficient he had bought more sophisticated knitting machines for which he had obtained free tuition, as he said, 'Without them you couldn't get going because it was too complicated.' As his interest progressed he had bought more sophisticated patterns and knitting machine magazines and books. His interest in knitting has also led him to become interested in other crafts such as decorating T-shirts and fabric painting. He had joined a local knitting club, but

because of using a hearing aid to combat his hearing loss he said, 'I'm not comfortable in the knitting class because of all the noise.' That said, he still went along from time to time. Another respondent was also interested in knitting and sewing, however, her expertise stemmed from her experience of being a College lecturer in fashion and design. She had managed to continue her interest by purchasing equipment that was specially adapted.

Whilst some respondents were able to continue the spare time activities which they undertook before they were disabled, this was not always the case. This was most frequently not possible for respondents with mobility problems, who had previously been involved in sporting activities. One respondent indicated that before he had a car accident which affected his mobility he participated in many sporting activities (swimming, badminton, squash, motor racing). After his accident he went swimming twice a week but found he could not keep it up.

Other respondents' interests had changed as they had become older. One respondent in his early 40s indicated that he started riding motor bikes when he was 16. He read books, magazines and went to rallies, auto jumbles and exhibitions. He was also a member of clubs and was president of one. When he needed advice on restoring motor bikes he indicated 'I would contact the owners' club and ask them, or look through magazines.' However, his interest in motor cycles terminated when he could not afford to run one in addition to a car.

Why people give up their interests is an important issue. Most of the work on self-directed learning has focussed on how people become interested, not why they give up. The motor cycle interest had largely given way to household Do-It-Yourself, something to be done out of 'necessity' rather than choice. He stated, 'The more major the job the more I enjoy it. I don't like putting shelves up and that sort of thing.' Asked how he had learned to undertake some of the DIY tasks he replied,

> "My father taught me, he used to be a builder ... I started building garages when I was about 6 years old ... when I had a job we used to talk about little jobs we did at home, and you pick things up that way I suppose."

This observation is a reminder of the possibilities of informal learning from fellow workers and in a working situation. The fact that many severely disabled people do not work may mean that they are missing an important source of learning opportunities.

8. Comment

The decision to interview a sample of disabled people was taken partly to provide a parallel with the enquiries into self-directed learning among carers. The crude hypotheses were that disabled people would (i) have the time and possibly the need; (ii) the motivation (because of difficulties of access to formal learning) to engage in self-directed learning both in relation to knowledge of their own condition and to interests, hobbies and spare-time activities.

The hypotheses were evidently too crude. What the interviews demonstrate is that need, availability of time and even motivation are not sufficient for engagement in self-directed learning. Disability, particularly if developing during adulthood, or occurring as the result of a traumatic event, may be an apparent example of an overpowering "organising circumstance". But they are not in themselves a sufficient condition of self-directed learning. Disabled people may lack the confidence and the necessary background skills. Their disability may introduce intervening factors which inhibit the impulse to self direction in learning. Preparation and assistance are needed (whether from professionals or peers is not clear) to assist in the movement towards what might be - in others - a naturally occurring phenomenon. In other words, adults in the community may all have the propensity to self-direction in learning but a propensity is not the same as the activity itself.

VI COMMENTARY

1. Generalisation and Theory

The choice of two very particular groups of people who were likely to be inhibited from social interaction and formal educational participation by their special circumstances may be said to limit the generalisability of these empirical studies. However, in investigations of self-directed learning, it is not yet clear how useful generalisation is likely to be. One of the problems in the initial utilisation of Allen Tough's insights and early research was the freedom with which some commentators moved from Tough's relatively small-scale and limited studies to global statements. Tough himself did not do this; but the somewhat moveable line between self direction in learning as an observable phenomenon and self direction in learning as a desirable educational goal to be achieved has encouraged the transition from the particular to the general. Even, some have prematurely moved to macro policy questions. If individuals in the community are learning for themselves, do we need formal provision of learning opportunities, they ask.

It is true, furthermore, that given attention which is more than cursory, our two groups of informal carers and disabled adults are far from homogeneous. The carers come from a wide profile of ages, educational and social backgrounds, and involvement in carers organisations. There is a broad span of physical and mental conditions among the care recipients for whom they are responsible. They have mixed attitudes to, and experience of, medical, health and social service personnel. Some reject the notion of 'spare-time activities' because, they say, there is no 'spare-time'. Others talk at length of their changing experience of learning about interests in their 'spare-time'. The small group of disabled adults vary across the range in terms of their physical conditions and the point in their lives at which disability became apparent. Those with the prior experience of being an able-bodied person with regular participation in the formal educational system, in work and in the social environment now presented with different attitudes towards the possibilities of self-directed learning from those with markedly different prior experience.

It has to be acknowledged that our empirical studies are partial and independent of the considerable social policy and social work literature that exists in relation both to informal caring and disability in society (see, for example, Twigg, Atkin and Perring 1990 and Finch 1989). Theory drawn from that literature would, of course, throw considerable light upon the phenomena which we have been observing. For example,

Twigg (1989) has explored confusion over the way in which the relationship between social care agencies and informal carers should be perceived: a confusion which goes some way to explaining the ambiguous role of social care professionals as sources of information and learning for informal carers which was discussed in Section IV above. Twigg's conceptualisation of three models which typify the perceptions held by professionals of informal carers does clarify the discussion - that is to say, carers as co-workers, carers as resources and carers as co-clients. However, the focus of this study is not primarily upon informal carers and disabled adults per se; it is upon two groups of adults in particular circumstances and the prevalence of self-directed learning among them. The theory which is relevant to this focus derives from the voluminous literature referred to in Sections I and II but, as this empirical study and the many others which ought to follow will show, the theory is incomplete.

2. Do informal carers and disabled adults engage in self directed learning?

To repeat the point, the theory is incomplete because the phenomena with which it is seeking to grapple are so complex. Selection and abstractions of issues are therefore necessary. The logically prior issue is do these adults - informal carers and disabled adults - engage in self-directed learning?

The answer, as these empirical studies have shown, is varied. The carers largely were placed in circumstances in which they had to learn about the condition of the person for whom they were caring, about the particular needs of that person and about the implications of actions which they as carers might take. They had to learn about the opportunities and difficulties which the pattern of state provision of professional assistance offered them and their dependants; they had to deal with financial benefits (although, as we indicated, knowledge here appeared often to have been inefficiently acquired). Often the new circumstances into which becoming a carer placed them (or, rather, were consequent upon the changed relationships in the household with the relative who became ill or disabled) meant that the carer has to acquire new ancillary skills and knowledge - homecare, managing financial affairs etc.

We say that the carers "had to learn". Of course, there was nothing deterministic about the situation. Our impression is that some carers deliberately set out to learn about the physical/mental condition of their care-receiver by reading, writing for information, asking professionals, asking others. This was not necessarily the norm, however.

More common might be a more immediate, less reflective, approach. The task is to cope, to survive. Caring itself would bring knowledge and skills: it was learning-on-the-job, learning from experience. Something might be picked up from medical/social service personnel but that knowledge might be generalised (coming from a limited knowledge of the specialised condition) or partial (coming from a particular disciplinary perspective). A support group might be joined and, as well as providing emotional and expressive support and a respite from the pressures of the domestic situation, this would provide regular opportunities for comparing notes and learning from others.

We were impressed by the quantity and range of 'spare-time activities' among the carers, given the demands upon their time and energies. Of course, they largely reported that they had less opportunity than formerly for these activities, and the activities tended to be of the kind that could be centered upon the home and discontinued or taken up as circumstances allowed. Such activities were in themselves a respite and a reaffirmation of the carers' individuality. They were more than a means of passing the time. 70% of the carers believed that their knowledge and skills in relation to the chosen activity had developed over time; they had improved; they had learned. We turn later to the question of how the carers evaluated their learning.

The picture is less certain for the disabled adults. Some deliberately set out to learn about their condition and its prognosis. Just as some long-term prisoners in gaol are reputed deliberately to use their enforced leisure to turn themselves into legal experts, so some disabled adults devour textbooks and journals, and engage in correspondence, in order to become as expert in their particular condition as any medical or social service professional. Other disabled adults preferred not to know; a fatalism or lack of confidence encouraged ignorance. With regard to 'spare-time activities', we derived no clear picture from our enquiry. Depending upon the nature of the disability, the daily pattern and the time available to a disabled person may not be as flexible, as manipulable, as for an able-bodied person. The notion of 'spare-time' may be especially a presumption. Health and energy, confidence and optimism, ebb and flow. Of course, disabled adults talked to us in interviews about 'spare-time activities', about what they learned and, in some instances, about the relationship of those current activities to what had gone before, before the trauma that led to the disability. But here we have a group of adults in a very special circumstance. Indeed, it is more than a circumstance. It is a whole world to itself from which a disabled person must struggle to maintain the continuities with the able-bodied world. We were stuck with the paucity of the potential learning environment for adults disabled from birth. It was

not just a matter of current physical isolation limiting opportunities; it was for some also the heritage of limited expectations and learning provision throughout life and internalised self-doubt, frustration and diffidence.

3. What learning resources do self-directed learners, who are informal carers and disabled adults, use?

Table 4 shows the range of limited contact which informal carers had with medical, health and social service personnel on a regular basis. Table 6 shows the varied sources of carers' knowledge about benefits. Thus, despite the fact that 61% of carers claimed to have no contact with social workers (and a further 17% saw a social worker only annually), 32% of carers regarded social workers as their source of knowledge on benefits. Of course, Table 5 shows the somewhat intermittent and inadequate nature of carers' knowledge of benefits. And social workers may well have been a more frequent source of knowledge at the onset of the experience of caring.

In Table 6, the role of voluntary organisations and carers' groups as sources of information, is worthy of note. So too, especially, is the fact that 'friends' are cited as a source of knowledge about benefits by 24% of carers. Friends may, indeed, be other carers or they may be individuals who have the time or inclination to seek out information on a carer's behalf.

What we do not derive, from this enquiry, is a picture of a convenient learning society, in which it is clear to the carer who has learning needs what information is available, in what form, from whom. The picture is of various official or voluntary agencies, organisations or individuals to whom one can turn. They are more or less accessible; largely one has to make an effort to reach them. There are also friends who are more accessible but may be less expert or well-informed. Books, official publications, TV, radio are rarely visible as sources of learning.

'Friends' again are shown to be significant in relation to carers' spare-time activities and interests. Table 10 suggests that of the 44% who can identify a beginning to their learning interest, 15% report that 'a relative or friend suggested it.' Table 12 indicates that, in the pursuit of their activity or interest, the informal carers were more likely to 'turn for advice' to magazines or books (41%) or to 'someone you regard as an expert' (33%). However, 36% would turn to a friend or relative (23% friends, 13% 'a member of the family'). It is important that fewer than half of the sample cite a written or published form of reference as their source of advice. More than half turn to

people. These people are not normally educators or librarians. They are either relatives or friends or someone regarded as 'an expert' or both; these are informal mentors.

The disabled adults, also, did not emphasise books or publications as learning resources. They did refer strongly to the role of television or radio. They talked of voluntary organisations as learning opportunities in relation to their condition. They also introduced the important dimension of time into the analysis. Some suggested, in effect, that societal attitudes to disability and the rights of the disabled, and changing attitudes and training (and better knowledge) within the medical, social service and health professions meant that professionals were more likely to be available as learning resources for disabled adults.

4. What is the process of self-directed learning for informal carers and disabled adults?

On the whole we saw little evidence of planned learning or deliberate intentional learning efforts in the empirical studies which we undertook. This observation is not, of course, necessarily surprising or a contradiction of the work of Tough and his replicators. Tough was looking for, researching, intentional learning in the community. We had a wider and more open brief.

We did not find much evidence of planned or intentional learning, but we did find evidence (self-reported evidence, admittedly) of learning both in relation to the social roles of being an informal carer or a disabled adult and with regard to what we termed 'spare-time activities'. In the area in which we expected to find intentional learning - the financially crucial use of knowledge about welfare benefits by carers - we largely did not find it. However, respondents had no difficulty in accepting, on reflection, that they were and had been learners. Table 7 seems to be particularly indicative. Carers were able to rank 'ways in which you have learned to look after somebody.' Our analysis suggests that the response-items contained in the question occupied different dimensions of meaning for the respondents. Carers truly and most immediately saw themselves learning on their own 'through a process of trial and error.' Of all the sources of help the most likely to have been used, at some time, were 'health and social science personnel'. Next most frequently cited were both friends and relatives and the full range of the tools of community self-learning (reading, TV and radio, tapes). Carers' groups and taught courses had been least important.

Both carers and disabled adults were more likely to respond to a question about when they began to pursue an interest or activity by saying that they 'had always been interested.' That is likely, indeed, to be true although there may well be a tendency in all of us to rationalise our biographies and to emphasis the continuities. The response also helps to emphasis the ambiguity or uncertainty of the boundaries between learning and life, between interests and everyday ongoing concerns. Educators most naturally think of well-defined courses and programmes with objectives and evaluation; there can be a beginning and an end. One may learn, and intend to learn, without a defined end in sight and without necessarily being conscious of a beginning. It is interesting that both carers and disabled adults might attribute to the trauma or experience of becoming disabled or becoming a carer the termination or reduction of time spent on an interest or activity.

What was striking about the responses of those who could identify a start to their pursuit of an interest or activity (Table 10) was the diverse, diffusive or even serendipitous nature of the explanation of that start. It may have been through change in circumstance; it may have been a suggestion by a friend or other person, perhaps something seen on television; or something which arose out of a chance occurrence. Not so much an 'organising circumstance' as a turn of the roulette wheel.

As the discussion of Table 12 above (pages 37-38) suggests the process of self-directed learning need not proceed in a linear, planned or rational manner. An interest can be a filter which distils from experience and the environment, information and skills which are perceived as relevant; it can be a set of hooks which takes hold of passing ideas, instances, resources and clues and brings them together into a unique formulation that makes sense to the individual. In a sense the terminology of 'self-direction' may be inappropriate; the connotation of 'direction' may be too firm, too deliberate. It is individually significant learning; to a degree it is self-managed; basically it is learning which is co-terminous with, and gives meaning to, living itself. This conclusion may be compared with that of Hasselkus and Ray (1988), in their study of caregivers in Wisconsin, in which they say that the informal learning of caregivers is "a lifelong process of reflection-in-action ...by which every person makes meaning out of their experiences and life situations."

5. How do informal carers and disabled adults evaluate their self-directed learning?

It is not necessarily the case that self-directed learners are concerned to evaluate their learning until asked to do so. Certainly, if there is no finite end to the learning, there is no requirement for summative evaluation.

However, in these empirical studies we discovered that the respondents had no difficulty in thinking about evaluation, about the means through which their learning might be judged. In the case of the informal carers and the measure of what they had learned about caring, the criteria seemed almost self-evident to them. They had survived; they had coped; to some degree they had routinised the extraordinary demands made upon. There was also a ready-made standard of comparison to hand against what they could measure the extent to which they had successfully learned how to provide for the needs of their care-receiver. Many carers took advantage of respite care facilities at least once a year for the person for whom they cared. Normally they considered that the care provided through respite was inferior to that provided at home. Of course, the carers were prosecution, judge and jury in such comparisons: there was no necessary objectivity in their assessment. However, it was true that respite care provided the carers with an external frame of reference within which to locate their own performance.

In the case of 'spare-time activities' 70% of the carers indicated, as stated earlier, that they thought their knowledge had developed since they began their chosen activity or interest. 60% said that they understood, and 40% that they felt 'more confident about it', and 28% that they can tell when they are making a mistake. What seems to be notable, however, are the significant proportions citing external, even objective, means of evaluation. 31% say that 'other people ask my advice'; 23% that they compare their ability 'with others'; 13% that they give talks or exhibit work; 10% that they 'have obtained an award/certificate; even 11% have earned money. These are not activities or interests hidden away timidly; a significant minority enter the public domain and are judged by others. It seems difficult not to give weight to this evidence of success.

It seems to be an enigma to talk about a 'successful' disabled adult and about degrees of success in learning to be a disabled adult. Yet this concept arose in our empirical studies of disabled adults. The engineer recorded forcibly that he had passed his 'trade, apprenticeship ... for being 'disabled'. He said 'it takes about thirty years to get fully qualified to know what you want'. Why so long? Because, in a sense, a disabled

person starts much further back than an able-bodied person. There maybe the emotions, frustrations and feelings of bitterness to come to terms with; there are the needs to cope with idiosyncratic, physical difficulties. There are differences between those born disabled, those who became disabled gradually and those disabled through an accident, traumatically. All of these are part of the 'apprenticeship' of being disabled and must be passed through even before seeking to embark on the educational processes in which able-bodied people engage. Largely, our respondents told us, all disabled people have different problems and needs; they have to work out things for themselves and in this sense are truly self-directed learners.

6. The particularity of conditions; the organising circumstance; and the contiguous resource

We deliberately chose for our empirical studies two particular groups of adults, largely to examine the possibility that their special circumstances and social isolation would make them less likely to participate in formal continuing education and more prone to engage in self-directed learning. On this somewhat generalised hypothesis we are no wiser. There is no evidence that the informal carers became more active as self-directed learners after they became carers, and no evidence that those adults who became disabled after an accident engaged in self-teaching in the post accident phase of their life. Each set of circumstances is so much more complicated that such crude hypotheses will allow: there is a range of intervening variables. In fact, many of the carers claimed that they had less time for both self-directed learning and formal education than before; nevertheless those with learning interests largely emphasised the continuity of those interests throughout adult life, regardless of when they became a carer. Disability might make an adult engage rigorously and determinedly on a learning project so that s/he can understand the disability and make improvements in the situation. Equally a lifetime of disability may find an adult lacking in learning confidence and unsure about study skills, or the trauma of an accident causing disability may leave an adult psychologically and/or physically unprepared to engage in learning of any kind. It is important to recall that our sample of disabled adults was not random. They were individuals known as active in disabled groups or otherwise recommended to us.

So we have to emphasise the particularity of the conditions of our respondents. It may be possible, after much more conceptual clarification and empirical investigation, to show that in the United Kingdom better educated adults or adults from particular cultures, age groups, social strata or regions are more likely to engage in self-directed

learning than others. However, for us, such a deterministic model of human behaviour seems unlikely to be relevant. We should prefer to start at the particular rather than the general. Our empirical studies included adults from different social backgrounds, age groups, educational experience etc. but these factors had only limited capacity to explain the attitudes and responses of the informal carers and the disabled adults in our studies. The foreground factors relating to their daily concerns, current circumstances and available life space seemed to have more explanatory power. Each condition was particular and the particularity of conditions related to a mixture of physical, psychological, financial, locational, social and other factors.

To what extent, then, have these studies shown the concept of the 'organising circumstance' to be a powerful explanatory tool for the advent and existence of self-directed learning among adults. Certainly the notion of the 'organising circumstance' does belong to a similar dimension to what we have called the particularity of conditions. Our analysis of self-directed learning among the carers and the disabled adults do not show rational decision-making and intentional planning as being the hallmarks of self-directed learning. To the contrary, adults did not break out of their circumstances and conditions; they worked with them, sought to cope with them and to survive them; they took the opportunities and resources for learning which were at hand, which presented themselves conveniently, which were part of their circumstances.

We looked extensively at the impact of becoming a carer upon the self-directed learning of the adults who were called upon, normally at short notice, to take on this role. We did not find that the new 'circumstance' 'organised' them. They did not necessarily follow the logical sequence of (i) recognising the need for new knowledge demanded by the circumstances (e.g. knowledge of welfare benefits) (ii) identifying the most accessible source of that knowledge (iii) moving to acquire that knowledge. Their new circumstances made all sorts of demands upon them but these did not include the acquisition of basic knowledge which would have made the new role more manageable. The circumstance neither compelled a particular kind of learning and certainly did not bring the resources for effective learning close to hand. So, on our analysis, the circumstance did not 'organise' - that, in fact, is too comprehensive , uni-dimensional and rational a verb for the context. Evidently 'circumstances' 'trigger' learning behaviour but what happens after the mechanism has been triggered can be unpredictable, inaccurate or ineffective. We prefer the 'triggering circumstance.'

We want to emphasis the latter analysis. Not only did the 'organising circumstance' not require a basic form of relevant self-directed learning, but it did not bring into the environment the relevant learning resources which not only would have made the learning easier and possibly more effective but may have, through their very existence 'triggered' off the relevant sequence of self-directed learning. The DSS, of course, has leaflets about welfare benefits; no doubt there are books to read, perhaps tapes to watch or hear. But hardly any of our sample used the leaflets, books or tapes or thought of doing so. It was more appropriate to ask a friend, or the social worker or community nurse, if one visited. The available learning resources were invisible. The informal carers did not construct their situation as being one in which they should actively seek information, perhaps undertake new behaviour themselves in order to learn. Rather the information should be on their doorstep, brought into their daily lives. Otherwise they would make do with what they could find.

We regard this question of the immediacy of learning resources to be key. Academics construe the world of learning as an active one; if one needs to learn one buys a book, goes to the library, checks a reference source, looks up one's notes. Most of the adult population do not behave in this way. Academics are trained to differentiate between resources; some resources are recognised as more authoritative than others and are therefore allowed more credence. It is not always so with all adults. We have laid emphasis in the reports on these empirical studies in the examination of the learning resources which self-directed learners in the community use. Our conclusion is that for self-directed learners, particularly when their learning is conceived as a process marked by serendipity and the coalescing of learning clusters, learning resources need to be contiguous in their environment or they will be invisible. Largely, they will not be sought and they will not be found. Within the particularity of their conditions, many adults will be triggered into a process of self-directed learning. They will use the learning resources to hand; the contiguous resource will probably determine the speed, effectiveness, quality and enjoyment of learning.

7. The role of the professional continuing educator

The professional continuing educator and the formal sector of continuing education (consisting of classes, courses and programmes) has had very little place in this report. Few of our informal carers or disabled adults attended continuing education classes (or 'night school'). Some had done so in the past, but this experience was not a major feature of their learning histories or learning environments as far as they, or we, were concerned.

How, then, may we conceive the relationship between the formal sector of continuing education and the world of adult self-directed learning, as we have begun to sketch it? Is there little necessary connection between them? Are professional continuing educators mainly providing a service for the middle and professional classes? Do the prevalences and potentials of adult self-directed learning make the formal sector of continuing education, as presently organised, less necessary.

We have begun to address some of the questions in the other report to have emerged from this research project (Percy, Burton and Withnall 1995). There we say:

> "the more likely prospect would be that better knowledge would allow the twin-phenomena of formal and informal adult learning to complement each other as part of the whole apparatus known as lifelong learning. We would expect perspectives from the self-directed learning phenomena - those, for example, of immediately and the organising circumstance - to reinforce current tendencies in the formal system such as the development of flexible, open and distance learning. We would expect perspectives of evaluation, of new technology, and of flexible learning materials, imported from the formal system, to influence the prevalence, nature and effectiveness, of self-directed learning among adults. It would be the professional continuing educator ... who would be charged with identifying, harmonising and revising these perspectives and with translating them into an effective future"
>
> (op.cit. 38-39)

Admittedly those phrases have something of a rhetorical ring about them and it is not self-evident how they can be translated into the new learning society as the next millennium dawns. It seems obvious to us that professional continuing educators have to raise their eyes above and beyond the rather low horizon of providing programmes of formal provision constrained by parameters of location, time duration and format. Developments of open and distance learning over the past twenty years are only a beginning and continue to be based upon models of adults as learners as continuing educators would have them be. It seems self-evident to us that developments in television, and new computer-based technology which will be accessible - potentially, and within financial contrasts - to all learners in their homes, workplaces, places of entertainment etc, will increase the possibilities which both learners and educators have at their fingertips. However, there are many missing links in our current thinking about

these possibilities. Complex technology can be available in the home but it can remain misunderstood, under-utilised, feared.

We think now that the notion of the 'contiguous resource' merits close examination, and extrapolation into the home-based technology environment which will be available to adult learners of the next decade. Learning resources relevant to all the conditions and stages of life, work, leisure and society need to be readily available to the adult who is potentially a self-directed learner at any time and location. These learning resources need both to be organically connected to the institutions of society with which the individual needs, or has contact with, during a lifetime and also immediately available to the adult learner in the life space and environment which s/he inhabits.

This is the concept of the organic learning society. The formal sector of continuing education, as we presently know it, will have a place in it. But it will probably be a secondary place. However, the formal sector of continuing education as it could be, should have a primary place. The provision of contiguous learning resources of quality, relevance and appropriateness, seems to us to be a highly complex task requiring disinterested professionalism, and a close association between research, theory and practice. This is the area of the future for the continuing educator from the formal sector.

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